Notice of Intent to Apply for the Rural Telemedicine Grant Program

APPLICANT

Name of Organization: ____________________
Address: ____________________
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Contact Name: ____________________
Phone Number: ( ) ____________________
Fax Number: ( ) ____________________
E-mai addressl: ____________________

OTHER NETWORK MEMBERS

Name of Organization/Facility: ____________________
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Address: ____________________
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Contact Name: ____________________
Phone/Fax Number: ( ) ( )

Name of Organization/Facility: ____________________
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Address: ____________________
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Contact Name: ____________________
Phone/Fax Number: ( ) ( )

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Address: ____________________
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Contact Name: ____________________
Phone/Fax Number: ( ) ( )

If needed, photocopy this page for additional network members

Please mail or fax this form to: Margaret Hardy/Rural Telemedicine Grant Program, Office for the Advancement of Telehealth,

5600 Fishers Lane, Room 11A-55, Rockville, Maryland 20857, Fax (301) 443-1330. Please respond by **February 16, 2000.**

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